State of Delaware
Flexible Spending Account
Enrollment Agreement
2010 Plan Year

As an employee becoming eligible to participate in the State of Delaware's Flexible Spending Account program within the current Plan Year (calendar year) I have reviewed the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations I have under the plan. I understand this agreement is irrevocable during this plan year except under special circumstances as outlined in the Summary Plan Description. I also understand that I will have a specified period of time after the end of the plan year or date of my termination to submit receipts for reimbursement for services received during the plan year or employment period. Any unused amounts remaining in my account at the end of this specified period of time will be forfeited. This agreement is subject to the terms of the State of Delaware Flexible Spending Account Plan. I hereby request to participate in the Health Care Account and/or Dependent Care Account with the annual election/s as indicated below and authorize my annual taxable salary to be adjusted based on my election/s for the remaining pay periods in this plan year.

Also, I understand that this request is for the current plan year and it is my responsibility to enroll to participate in future open enrollment periods for future plan years.

Employee I.D. Number _____

Name _____ _____
(Last, First MI) Agency/School District Name

Street _____ _____
Employee Daytime Phone Number

City, State, Zip _____

Annual Election
For the Plan Year

Health Care Flexible Spending Account $_____
(Minimum $50, Maximum $4,000)

Dependent Care Flexible Spending Account $_____
(Minimum $50, Maximum $5,000)

* Your annual election will be divided by number of pays remaining in the calendar year.

DIRECT DEPOSIT REIMBURSEMENT enrollment information is available at www.ben.omb.delaware.gov/fsa/index.shtml.

Employee's signature: _____ Date:_____

Please contact Statewide Benefits at (302) 739-8331 with questions.

Return this form to Statewide Benefits by fax, (302) 739-8339